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October 1, 2016

The Honorable Sylvia Mathews Burwell, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

**Re: Oregon Health Plan 1115 Demonstration Extension
Proposal**

Dear Secretary Burwell,

We appreciate the opportunity to comment on Oregon's proposal to amend and extend its comprehensive demonstration project known as the Oregon Health Program. The National Health Law Program (NHeLP) advocates, educates, and litigates at the federal and state levels to protect and advance the health rights of low income and underserved individuals.

We support many of the proposals in the State's application, especially the focus on addressing social determinants of health, better integration of mental health care, and health equity as ways to improve health outcomes. The State's commitment to Coordinated Health Partnerships to support access to housing and supportive services for vulnerable populations, its focus on tribal health, and expanded use of targeted case management for children should help improve health equity. We look forward to seeing more detail about how the provisions will be implemented within the current CCO structure and how they will be evaluated.

However, we have the following concerns:

1. The application does not sufficiently address how the purpose of the 1115 demonstration program and the goals of Oregon's health care transformation are met by the continued use (and very strict application) of the long-running OHP Prioritized List. CMS should require Oregon to stop using the Prioritized List.

2. Oregon neither offers a demonstration purpose nor justifies the continued waiver of EPSDT requirements for individuals under 21. The state-commissioned evaluation of the demonstration does not even mention, let alone evaluate, the impact of past EPSDT waivers on health outcomes for low-income children. The continued waiver of these key requirements should not be granted unless and until a robust analysis of the impacts on children's access to medically necessary treatment has been completed and made publicly available, the State has explained why this critical bridge to community health is not being fully implemented, and the State has provided a valid demonstration/experimental purpose for waiving EPSDT beyond pure cost control (which, of course, is an illegal justification for a waiver).
3. The application does not adequately address what oversight and due process requirements will apply to the continued and expanded use of flexible services (called health related services in the application). Currently, flexible services are only available to those enrolled in a CCO, and the CCO's administer those flexible services largely without transparency or the basic due process rights that individuals with Medicaid receive in all other contexts. With the proposed expansion of flexible services to include things like housing and supportive services, the waiver must clarify the State's and CCO's duties to be transparent and provide due process with regards to flexible services and health related services.
1. **The portion of the current 1115 demonstration that allows limiting health care by using the Prioritized List is inconsistent with §1115 of the Social Security Act.**

Section 1115 provides states flexibility to design experiments aimed at improving their Medicaid programs and promoting the objectives of the Medicaid program. When Oregon first proposed its 1115 demonstration over 25 years ago, the project was supposed to test whether Oregon could expand eligibility and manage costs by using a Prioritized List of Health Services to decide which health care services would be covered for Medicaid recipients (a provision that was to be expanded to all state residents but never was). Many demonstration waiver extensions and amendments have been granted since then. Through them all, the impact of the Prioritized List and its underlying methodology has not been adequately evaluated despite a consistent "raising of the line" that restricts access to more and more treatments, even when they may be medically necessary. In the wake of the Affordable Care Act's Medicaid expansion, enrollment expansion can no longer validly justify maintaining a prioritized list that effectively rations care, particularly for children who should have the statutory entitlement to EPSDT. The State is under considerable pressure to produce budget savings under the current CCO model. In this context, the State must justify how the continued use of the Prioritized List meets any experimental or demonstration goal (of course, not including the goal of containing costs by limiting medically necessary care).

Before approving another extension for the Oregon Health Program, CMS should require the State to explain how the 25 year practice of strictly limiting medical care to those services exactly matched by a condition-treatment pair on the Prioritized List of Health Services between lines 1 and the ever-more restrictive cut-off line, served a demonstration purpose beyond budget control. As important, CMS should require Oregon to stop using the Prioritized List. The State's current justification for the continued application of the list is simply to prevent cutting services or provider rates.¹ Research conducted on the efficacy of the Prioritized List has indicated that the Prioritized List neither expands eligibility for medical care nor reduces costs.²

a. Continued use of the Prioritized List contradicts the State's goals and strategies towards achieving transformation.

Oregon has been forward thinking, creative, and ambitious in shifting focus towards achieving "health care transformation" through the triple aims of 1) better health, 2) better care, and 3) lower costs. The proposed amendments to OHP continue this trend by seeking to improve the health of Oregonians by addressing the social determinants of health and health equity. However, the original 1115 demonstration waiver from 1994 (that the state is currently seeking to extend) allows Oregon to strictly limit Oregonian's access to health care based not on the transformation goals, but on a statewide, pre-set, largely inflexible Prioritized List of services. Furthermore, since the original 1994 waiver approval, the Prioritized List has allowed funding for fewer and fewer condition-treatment pairs. Originally the Prioritized List allowed coverage for more than 600 lines on the Prioritized List, and now it only allows coverage for items 1-476. Several published papers have questioned the basis upon which the priority has been judged, and the criteria for weighting and ranking services have changed several times over the last two plus decades.³

When it first approved Oregon's use of the Prioritized List, CMS required the State to allow variances from the List when required by medical necessity. Today, the Prioritized List is applied inflexibly, and even exceptions based on co-morbidity are infrequent. This strictly applied, ever more restrictive Prioritized List obstructs health care professionals' ability to treat individuals based on their particular medical needs. The inflexibility of this system that can seriously impact beneficiaries' health and well being, and is especially harsh when children and people with disabilities cannot get treatments their providers deem medically necessary.

Oregon's health care transformation emphasizes preventive medicine and primary care homes to encourage coordinated, effective and individualized plans for health care that will result in better health outcomes and less need for medical care. The demonstration

¹ Oregon Health Plan 1115 Demonstration Extension Proposal, 272 (Sept. 1, 2016), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/or/or-health-plan2-pa3.pdf>.

² J. Oberlander et al., *Rationing medical care: rhetoric and reality in the Oregon Health Plan*, 164 CMAJ 1583 (2001); Jonathan Oberlander, *Health Reform Interrupted: The Unraveling of the Oregon Health Plan*, 26 HEALTH AFF. W96 (2007).

³ Tammy Tengs et al., *Oregon's Medicaid Ranking and Cost-Effectiveness: Is There Any Relationship?*, 16 MED. DECIS MAKING 99 (1996); Jonathan Oberlander, *supra* note 2.

application seeks to expand the patient-centered primary care home program and add outcome-based metrics for measuring CCO performance. However, continued application of the strictly applied limits of the Prioritized List will conflict with these stated elements of transformation. Continued use of the Prioritized List takes decision making out of the hands of the providers and conflicts with the notion that the providers are responsible for managing their beneficiaries' care. Moreover, the success of health transformation cannot be accurately measured so long as the Prioritized List is in place.

b. The section 1115 waiver should require coverage of services that are medically necessary so that coverage will be equitable.

Neither the State nor CMS may waive the Americans with Disabilities Act, section 504 of the Rehabilitation Act, the Mental Health Parity Act, or § 1557 of the Affordable Care Act. A quarter of a century ago – when the original Prioritized List was approved – the ADA had not taken hold and the ACA did not exist. The current limitations on the scope of services available to OHP enrollees are outdated, overly restrictive and unresponsive to individual clinical contexts. We recommend that the OHA commit to a process to expand the conditions covered and promptly phase out the Prioritized List in favor of allowing the CCO demonstration to take hold.

2. The application does not and cannot justify the continued waiver of EPSDT requirements for individuals under 21.

In establishing EPSDT, Congress clearly intended that Medicaid programs take affirmative and aggressive steps to ensure that children and adolescents get prompt access to needed care, including screening and all Medicaid-coverable services when necessary to correct or ameliorate their conditions. See 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r). The literature has thoroughly established the importance of regular screenings and early intervention and treatment to improve long-term health outcomes for young people. CMS's recently issued EPSDT Coverage Guide for States repeatedly notes the purpose of EPSDT – to ensure the right services for the right child at the right time and in the right setting. Numerous federal courts of appeals have noted that the “broad” EPSDT coverage requirements are meant to ensure that each child gets the care they need. In addition to the broad screening and clinical coverage requirements, the EPSDT statute and regulations establish a community-facing role for EPSDT—where EPSDT programs are coordinated with nutritional, housing, educational and other community programs. As States embark on health transformation, these bedrock Medicaid provisions should not be waived. Rather, States should be required to explain how they will affirmatively and aggressively include them in their demonstration/experimental projects.

Oregon's proposal to waive EPSDT has no justification. Rather, its waiver of EPSDT suggests it is sufficient to treat children over the age of one using the same Prioritized List that it applies to the adult Medicaid population. The State provides no evidence to support that this limitation will not negatively impact children who require treatments that happen to fall below the line set by the state legislature (not their CCOs/doctors.) The

only plausible reason for Oregon to seek this waiver is to save money, and saving money is not an adequate reason to waive such a key Medicaid requirement.

3. The application should be explicit that additional “flexible services” or “health related services” must comply with constitutional and Medicaid due process procedures and other quality assurance safeguards.

The current 1115 waiver specifically allows Coordinated Care Organizations (CCOs) to provide flexible services to its members as part of the demonstration waiver services. The waiver amendment application seeks to expand the provision of similar services, called “health related services” that could address the social determinants of health and health equity and count them as reimbursable medical services rather than administrative costs. While the provision of such “health related services” would be a welcome addition to the more traditional Medicaid services, the application is silent on two critical elements of providing such Medicaid services – due process and statewide uniformity.

Currently, the State does not offer flexible services to anyone unless they are enrolled in a CCO. These services are not available to fee-for-service OHP members. Additionally, the state does not require that CCOs give enrollees due process rights to notice and an opportunity to challenge a denial of flexible services.

The application for waiver extension/amendment does not address either of these issues. We feel strongly that if the State expands Medicaid services to include important but non-traditional “health related services,” these services must be available to all OHP enrollees, and cannot operate as “secret benefits” as they currently do. (Of course, we are concerned that medically necessary services that individual beneficiaries need, that happen to fall below the ever-expanding “below the line” cut off, are automatically off-the-table as CCOs make this highly discretionary use of Medicaid funding for related services.)

Moreover, where a CCO covers these flexible services, OHP enrollees may not know about them. If an enrollee is lucky enough to have a provider ask for such services, but they are denied, the enrollee does not have a right to know the basis for the denial or have an opportunity to challenge the denial. We request that the State make it clear that all “health related services” and all “flexible services” are Medicaid services. And as Medicaid services, the basic Medicaid and constitutional due process protections apply.

Further, we suggest that the State specifically address how the CCOs will be held to the same standards of transparency to the public as the state Medicaid agency. Currently, the State contracts out most of the essential duties of a state Medicaid agency to private companies that do not readily (or sometimes at all) share their policies and practices with the public, or in some cases, even to their members. This seriously hampers efforts to determine if the CCOs are operating in compliance with federal laws, and it erodes the public’s confidence in the system. We support efforts to use flexibility and creativity to solve the health care and health care cost problems faced by the State, but we

believe that transparency and accountability are also critical to the success of the transformation process.

Again, thank you for the opportunity to comment on the Oregon Health Plan demonstration proposal. We are genuinely hopeful that coordination between health care benefits and other social determinants of health and health equity such as housing stability, integrated mental health care, and safety from domestic violence will greatly improve the health of Oregonians. But we also urge CMS to not reapprove Oregon's outdated Priority List and EPSDT waiver. Please feel free to contact David Machledt, Machledt@healthlaw.org, or me, perkins@healthlaw.org, with any questions about the above comments.

Sincerely,

Jane Perkins,
Legal Director